HIV/AIDS Monitoring Report

This form is filled out by the Service Coordinator or other person assigned to monitor the consumer's overall well being

Consumer's Initials:_____ DOB:_____ Sex:_____ Race:_____
Dates of Contact:_____
Address:_____
Phone number:_____
Name of Physician: _____

1. **1. Diet (please comment on any diet , appetite or weight changes):**

   _____
   _____

2. **Physical health (general health status, last physician's visit, lab work done, if any):**

   _____
   _____

3. **Current Medications:**_____
   _____

4. **Mental Health (affect, behavior, attitude, etc.):**

   _____
   _____

5. **Sexually active? (any sexual activity, condom use) :**

   _____

6. **Training/Counseling? (any training/ counseling this quarter about HIV+/ AIDS)**

   _____

7. **Activity or recommendations since last report:**

   _____
   _____
   _____

8. **Level of Supervision Needed:**

   _____

Submitted by: _____ Date: _____
Title: _____ County/Region:_____
Date of Death:_____

(Upon completion please submit reports to the DDSN Director, Division of Quality Assurance)